Governor's Proposed May Revision Budget
Trailer Bill Language

Transition of Healthy Families Program (HFP) Children to Medi-Cal

SEC. 4. Section XXX of Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code is added to read:

(a) It is the intent of the Legislature that all existing enrollees in the Healthy Families Program pursuant to this Part will, as of January 1, 2012, transition to other health care coverage programs pursuant to Section 14005.27 and Chapter 6 (commencing with Section 15850) of Part 3.3 of Division 9 of the Welfare and Institutions Code.
(b) The Healthy Families Program pursuant to this Part will cease to enroll new applicants as of January 1, 2012.
(c) The Healthy Families program pursuant to this Part will cease to operate when all enrollees are transitioned to new health care coverage programs pursuant to Section 14005.27 and Chapter 6 (commencing with Section 15850) of Part 3.3 of Division 9 of the Welfare and Institutions Code .

SEC. 5. Add Section 14005.27 to the Welfare and Institutions Code, as follows:

(a) The department shall exercise the option pursuant to Section 1902(a)(10)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full scope benefits under this Chapter and Chapter 8 to optional targeted low-income children pursuant to 1905(u)(2)(B) of the Social Security Act (42 U.S.C. section 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a State Plan Amendment to implement this subdivision.
(b) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the Federal Poverty Level for the individuals described in subdivision (a). The department shall seek federal approval of a State Plan Amendment to implement this subdivision.
(c) For the purposes of carrying out the provisions of this section, in performing initial eligibility determinations for children enrolled in the Healthy Families Program on the date this section is implemented pursuant to subdivision (j), the department shall adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon a finding of initial eligibility by the Managed Risk

Medical Insurance Board (MRMIB) or its successor agency. The department shall seek federal approval of a State Plan Amendment to implement this subdivision.

(d) To the extent necessary, the department shall seek federal approval or a waiver to provide presumptive eligibility under this section for individuals enrolled in the Healthy Families Program (HFP) on the date this section is implemented under subdivision (j). The presumptive eligibility for individuals under this section shall be based upon information contained in the individual's most recent annual review under the Healthy Families Program (HFP). The timeframe for the presumptive eligibility shall begin on the date this section is implemented under subdivision (j) and shall continue until a determination of Medi-Cal eligibility is made, using the individual's next HFP annual review date as the date for that determination.

(1) Notwithstanding any other provision of law, presumptive eligibility for benefits under this section for children who, at the time of enactment of this section, have made an application for and have not yet been determined eligible for HFP or are in the HFP shall be provided and the process of determining such eligibility shall be implemented in accordance with any federal approvals obtained.

(e) Notwithstanding any other provision of law, including sections 11050 and 14016, and only to the extent federal financial participation is available through any necessary federal waiver or state plan amendment, the state may enter into arrangements with select counties to perform final eligibility determinations and redeterminations under this section.

(f) (1) Individuals eligible for benefits under this section, who are enrolled in the HFP on the date this section is implemented under subdivision (j), shall, unless they choose otherwise, be enrolled in the same health plan that they were enrolled in for HFP if such plan is a Medi-Cal managed care plan or a subcontractor of a Medi-Cal managed care plan, or a dental managed care plan. If the existing HFP plan is not a Medi-Cal managed care plan, to the extent possible, with assistance from the Managed Risk Medical Insurance Board or its successor agency, the department will develop a process to enroll the individual into a Medi-Cal managed care plan that includes their current primary care provider.

(2) If the county in which such individual resides on the date this section is implemented under subdivision (j) is a Medi-Cal County Organized Health System (COHS) county, the individual will receive health care coverage from the COHS.

(3) If the county in which such individual resides is not a Medi-Cal managed care county, health care services will be provided under the Medi-Cal fee-for-service delivery system. For individuals provided health care services under the Medi-Cal fee-for-service delivery system, the department, in consultation with stakeholders, shall develop a process for transitioning these individuals into the Medi-Cal fee-for-service delivery system.

(4) If the county in which such individuals resided is not a dental managed care county, dental services will be provided under the Medi-Cal fee-for-

service delivery system. For individuals provided dental services under the Medi-Cal fee-for-service delivery system, the department, in consultation with stakeholders, shall develop a process for transitioning these individuals into the Medi-Cal fee-for-service delivery system

(5) Individuals eligible for benefits under this section, who are enrolled in the HFP on the date this section is implemented under subdivision (j), may elect to enroll into a dental managed care plan if such plan is available in the individual's county. If the county is a dental managed care county, it will fall under one of two categories: mandatory or voluntary. In a mandatory county, dental services will be provided by a dental managed care plan. In a voluntary county, the individual has the option to select either a fee-for-service delivery system or a dental managed care plan.

(g) (1) The department shall consult with stakeholders regarding implementation of the transition of individuals enrolled in the Healthy Families Program on the date of implementation of this section under subdivision (j) to Medi-Cal with the goal of ensuring continuous coverage for transitioning individuals.

(2) The department shall inform individuals enrolled in the Healthy Families Program on the date of implementation of this section under subdivision (j) by written notice at least three months prior to their transition to Medi-Cal. Such notice shall contain information regarding the transition, including but not limited to: how their system of care may change, when the changes will occur, who they can contact for assistance with choosing a managed care plan, if applicable, and with problems they may encounter. The department shall consult with stakeholders in developing such notice. The notice shall be developed using plain language and written translation of the notice shall be available for those who are limited English-proficient or non-English speaking, pursuant to the Dymally-Alatorre Act (commencing with section 7290 of the Government Code).

(3) With assistance from the Managed Risk Medical Insurance Board or its successor agency, the department shall analyze the existing Healthy Families Program delivery system network and the Medi-Cal fee-for-service provider networks to determine overlaps of the provider networks in each county for which there are no Medi-Cal managed care plans. To the extent there is a lack of existing Medi-Cal fee-for-service providers serving the Healthy Families children, the department will work with the Healthy Families Program provider community to encourage and develop a streamlined process to enroll as a Medi-Cal provider.

(h) The department shall exercise the option pursuant to the federal Social Security Act Section 1916A (42 U.S.C. section 1396o-1) to impose premiums for individuals described in (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, as determined pursuant to subdivision (b). The department shall obtain federal approval for the implementation of this subdivision.

(i) This section shall be implemented only to the extent that federal financial participation is available, and only to the extent that the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act is available for targeted low-income children pursuant to that Act.

(j) This section shall be implemented beginning on January 1, 2012 or when necessary federal approvals and waivers have been obtained, whichever is later, and then only to the extent that such federal approvals and waivers have been obtained. To ensure a smooth transition for existing HFP enrollees, upon obtaining all necessary federal approvals and waivers, implementation of this section shall occur over a six-month period.

(k) Notwithstanding section 14154 or any other provision of law, for the purposes of implementing this section, the department shall develop a case rate reimbursement methodology for Medi-Cal county administration costs for eligibility operations. Final eligibility determinations made pursuant to this section shall be performed by county eligibility workers.

(l) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government code, the department shall, without taking any further regulatory action, implement, interpret or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

(m) To implement this part, the department may contract with public or private entities. Contracts entered into under this part may be on a non-competitive bid basis and shall be exempt from the following:
(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures or regulations authorized by that Part.
(2) Article 4 (commencing with Section 19130) of Chapter 5, of Part 2 of Division 5, of Title 2 of the Government Code.
(3) Review or approval of contracts by the Department of General Services.
(4) Review or approval of Feasibility Study Reports and the requirements of State Administrative Manual sections 4819.35 through 4819.37 and 4920 through 4928.

(n) If at any time the director determines that this section or any subdivision of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After giving notice, this section or any subdivisions of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or subdivisions thereof in order to receive federal financial participation, any increase in the FMAP available on or

after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case this section or subdivisions thereof shall be inoperative.

SEC. 5. Section 14011.6 of the Welfare and Institutions Code 14011.6 is amended to read:

(a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program for accelerated enrollment of children.

(b) The department shall designate the single point of entry, as defined in subdivision (c), as the qualified entity for determining eligibility under this section.

(c) For purposes of this section, "single point of entry" means the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal Program for the purpose of forwarding them to the appropriate counties.

(d) The department shall implement this section only if, and to the extent that, federal financial participation is available.

(e) The department shall seek federal approval of any state plan amendments necessary to implement this section. When federal approval of the state plan amendment or amendments is received, the department shall commence implementation of this section on the first day of the second month following the month in which federal approval of the state plan amendment or amendments is received, or on July 1, 2002, whichever is later.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all-county letters. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) Upon the receipt of an application for a child who has coverage pursuant to the accelerated enrollment program, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall report this finding to the Medical Eligibility Data System so that accelerated enrollment coverage benefits are discontinued. The information to be reported shall consist of the minimum data elements necessary to discontinue that coverage for the child. This subdivision shall become operative on July 1, 2002, or the date that the program for accelerated

enrollment coverage for children takes effect, whichever is later.

(h) To implement this section, the department may contract with public or private entities. Contracts entered into under this part may be on a non-competitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures or regulations authorized by that Part.

(2) Article 4 (commencing with Section 19130) of Chapter 5, of Part 2 of Division 5, of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

Review or approval of Feasibility Study Reports and the requirements of State Administrative Manual sections 4819.35 through 4819.37 and 4920 through 4928.

LANGUAGE WILL BE ADDED TO ENSURE THE SAME COUNTY/STATE FINANCING ARRANGEMENT FOR CCS AND MENTAL HEALTH SERVICES FOR MEDI-CAL CHILDREN WHO WOULD HAVE BEEN COVERED UNDER HEALTHY FAMILIES PRIOR TO JANUARY 1, 2012.